

Supplement 1 to Attachment 3.1-A

State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

At Risk Children

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible youth that meet specific needs based criteria and are “at risk” of offending or victimization due to medical, environmental, social, economic, and family conditions that hinder their personal development and successful integration into society. Substance abuse, addictive disorders, intellectual disabilities, developmental disorders, and emotional disorders are not included. In order to be eligible for targeted case management services, the qualifying “at risk” behavior or circumstances must be documented in the record.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual’s needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

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- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in

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obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

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Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Early Intervention

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible children birth to age 6 who have or suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay and/or intellectual disabilities.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- Entire State
 Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
 Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.

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- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

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The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

The State assures that:

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- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

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Limitations:

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FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Individuals with Serious and Persistent Mental Illness

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible individuals age 21 and older who have a major mental disorder included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders classification under schizophrenia disorders, major affective disorder, severe personality disorder, psychotic disorder, and delusional (paranoid) disorders or diagnosis of a mental disorder and at least one hospitalization for treatment of a mental disorder.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.

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- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

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The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Providers are limited to staff of the state's Department of Mental Health and the Medical University of South Carolina Institute of Psychiatry that have been designated in accordance with SC Code of Laws to treat persons with serious and persistent mental illnesses. All case

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management providers or provider agencies must sign a provider agreement and meet all applicable state and federal laws governing the participation of providers in the Medicaid program.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

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DRAFT

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**State Plan under Title XIX of the Social Security Act
State/Territory: South Carolina**

TARGETED CASE MANAGEMENT SERVICES

Children with Serious Emotional Disturbances (SED)

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible children age 6 through 21 who currently or at anytime during the past year (continuous 12 month period) have:

- A diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the DSM. This excludes substance abuse or addictive disorders, irreversible dementias, Intellectual Disability, developmental disorders, and V codes, unless they co-occur with another serious mental illness that meets DSM criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities; all of these disorders have episodic, recurrent, or persistent features: however they vary in terms of severity and disabling effects; and
- A functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Temporary and expected responses to stressful events in the environment are not included. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

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- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

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- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and

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- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager:

1. Must have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Providers are limited to staff of the state's Department of Mental Health, the Medical University of South Carolina Institute of Psychiatry, Continuum of Care and Intensive Foster Care and Clinical Services Division that have been identified by SC Code of Laws to serve children with serious emotional disturbances. All case management providers or provider agencies must sign a provider agreement and meet all applicable state and federal laws governing the participation of providers in the Medicaid program.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

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Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Individuals with Psychoactive Substance Disorder

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible individuals who are at risk of substance abuse, dependency or addiction or diagnosed with a substance disorder, psychoactive substance dependency, or induced organic mental disorders as defined in the current edition of the Diagnostic and Statistical Manual or individuals who have received treatment in an intensive alcohol and drug abuse treatment program or chemical dependence hospital.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

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- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

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The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Individuals with Intellectual and Related Disabilities

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible individuals with a confirmed diagnosis of Intellectual Disability defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental phase, prior to age 18 years, OR a related disability as defined as a severe, chronic condition found to be closely related to retardation Intellectual Disability and meet the four following conditions:

1. It is manifested before 18 years of age for Intellectual Disability and prior to 22 years of age for related disabilities. AND
2. It is likely to continue indefinitely.
3. It results in substantial functional limitations in 3 or more of the following areas of major life activities: Self Care, Understanding and use of language, learning, mobility, self-direction, and capacity for independent living. AND
4. The person's needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultive behavior or because drug effects/medical monitorship. AND
5. The person is in need of services directed toward acquiring skills to function as independently as possible or the prevention or regression or loss of current optimal functional status.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(G)(1) OF THE Act):

- X Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

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- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or

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provider at least every sixty (60) days to ensure appropriateness of continued services.(E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441. 18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.

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- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Providers are limited to provider agencies or entities that meet the targeted case management provider qualifications and have been approved as Qualified Providers by the state's Department of Disabilities and Special Needs in accordance with SC Code of Laws. All case management providers or provider agencies must sign a provider agreement and meet all applicable state and federal laws governing the participation of providers in the Medicaid program.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities

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constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(25) and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Head and Spinal Cord Injuries and Related Disabilities

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible individuals determined to have a traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, dementia, or a neurological disorder related to aging, regardless of the age of onset. Where the individual has substantial functional limitations and:

1. Has urgent circumstances affecting his/her health or functional status; and
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(G)(1) OF THE Act):

- X Entire State
_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- _ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

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- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

__Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

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The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Sensory Impaired

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible non-institutionalized individuals between the ages 0 to 64 who have been diagnosed as legally blind, visually impaired, deaf, hard of hearing or multi-handicapped by a qualified specialist in the area of vision or hearing.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.

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- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, , to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441. 18(b)]:

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The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;

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- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

At Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible first time pregnant women age 21 years or older who are not beyond the 28th week of pregnancy. The mother must be willing to receive visits from a nurse during pregnancy and continue up to the infants second birthday. Individuals must meet one or more of the following conditions:

1. Is expecting her first live birth and has never parented a child;
2. Has previously been pregnant, but experienced a stillbirth, miscarriage, or had an abortion;
3. Has previously parented a child, but her parental rights were terminated;
4. Has delivered a child, but the child died within the first 24 months of life; or
5. Has parented a child but there is an age gap of 15 or more years since last delivery.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- _ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case Mmanagement includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and

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- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible

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individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of

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ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

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Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Persons at Risk for Genetic Disorders

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Medicaid eligible individuals who have been diagnosed with a genetic disorder, have preliminary laboratory tests showing evidence of a disorder or individuals who have a family member with an illness which is associated with a genetic disorder. The individual must be referred by the doctor of the individual who has been diagnosed with an illness which is caused by a genetic disorder.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

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- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
6. Have adequate administrative capacity to fulfill State and Federal requirements.
7. Have financial management capacity and system that provides documentation of services and costs.
8. Have the capability to ensure payment for case management or targeted case management services under the plan does not duplicate payments under other program authorities for the same purpose.

The Targeted Case Manager must:

1. Have an employment or contractual relationship with the provider entity.
2. Possess baccalaureate or graduate degree from an accredited college or university in social work, nursing, special education, early childhood education, criminal justice, sociology, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body.
3. Have the ability to access multi-disciplinary staff when needed.
4. Have documented experience, skills, or training in:
 - a. Crisis Intervention, and
 - b. Effective Communication, and
 - c. Cultural diversity and competency,
5. Possess knowledge of community resources,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice [42 CFR 441.18(a)(1)]:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of any qualified Medicaid providers within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:

___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services [42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)]:

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The State assures that:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment [42 CFR 441.18(a)(4)]:

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. All services must be prior authorized. Payment is based on the lesser of the billed amount or Medicaid maximum allowable for each procedure.

Case Records [42 CFR 441.18(a)(7)]:

Providers maintain case records that document for all individuals receiving case management As follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the Provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) The need for, and occurrences of coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid manual (SMM) 4302.F.)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation related to the foster care program; assessing adoption placements; recruiting or interviewing potential foster parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. [42 CFR 441.(18)(c)]

FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. [§1902(a)(250 and 1905(c)]

Case management does not include activities to clients participating in any waiver program that includes case management services.

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State Plan under Title XIX of the Social Security Act

State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Functionally Impaired Adult

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Coverage is limited to individuals in need of services and meet the following criteria:

- Individuals who are 18 years of age or older.
- Individuals who lack formal or informal resources to address their mental and physical needs.
- Individuals who are unable to perform at least one Activity of Daily Living (ADL) as defined in the state Nursing Facility Level of Care Criteria.
- Individuals who require TCM assistance to obtain needed services.

X Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of Services (§1902(a)(10)(B) and 1915(g)(1)):

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services: (42 CFR 440.169):

Targeted case management services are services furnished to assist individuals, defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted case management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

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- Assessments shall be conducted at least twice annually, but may occur more frequently when significant changes occur or new needs are identified.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the eligible individual) to help the eligible individual obtain needed services including:
 - Activities that help link an individual with:
 - Medical, social, and educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - Changes in the needs or status of the eligible individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The following monitoring requirements must be performed and documented in the record as follows:

- Face-to-Face with the eligible individual at least once every six months; and
- Face-to-Face, telephone, or e-mail contact with the eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness of continued services. (E-mail contact is used only when other attempts have failed)

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care purposes of helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining service; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. [42 CFR 440.169(e)]

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Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:

The provider entity must:

1. Be certified by SCDHHS or its designee as a qualified Case Management entity.
2. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program including, but not limited to the ability to meet Federal and State requirements for documentation, billing, and audits.
3. Have the responsibility for providing a statewide system for the delivery of community services to individuals in the State in accordance with the South Carolina Code of Laws.
4. Limited to in-state providers only.
5. Have legal financial authority under Federal and State Laws to provide the required Medicaid match for services to be provided.
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Case management does not include activities to clients participating in any waiver program that includes case management services.

REIMBURSEMENT LANGUAGE FOR THIS SPA WILL BE ADDED AS THEY BECOME AVAILABLE.

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